Metropolitan Nashville Public Schools
REQUEST FOR: ASSISTED SELF-ADMINISTRATION OF MEDICATIONS PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS

Requests for a student to administer his/her own medication during school hours requires that this statement be filed with the school principal. Please respond to every item on this form.* If non-prescription, parent fills out health care provider part.

School _____ School Hours _____ Teacher _____

STUDENT INFORMATION

Student Name _____ Date of Birth _____/____/____
Last First Middle

Address _____ Phone _____

Diagnosis (Optional) _____

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (M.D.), physician assistant (P.A.) or a registered nurse practitioner/clinician (RN CS).

To be completed by the health care provider. (If non-prescription medication, parent must fill out.)

Name of Drug _____

Date to Start _____ **through** _____

Dosage and Times at School _____

Does this medication absolutely need to be administered during school hours?

_____yes _____no If yes, explain _____

Special instructions for Storage and Handling _____

_____

Possible side Effects _____

Health Care Provider Name _____ **Phone** _____

Address _____

Health Care Provider Signature _____ **Date** _____
(for prescription medications)

Parent Signature _____ **Date** _____
(for non-prescription medications)

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicine bottles will have the proper pharmacy label. If non-prescription medication, it must be in original container.

Student Signature _____ **Date** _____

I give consent for my child (name) _____ ***to take his/her own medication during the school day assisted by school personnel as necessary. My child is competent to self- administer the medication with assistance*.** _____ **yes** _____ **no (Check one)**

Parent/Guardian Signature _____ **Date** _____

Phone Number (in case of emergency) _____